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What's the harm in asking? A systematic review and meta-analysis on the risks of asking about suicide-related behaviors and self-harm with quality appraisal

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ABSTRACT

Research emphasizes the importance of asking about suicidality. Unfortunately, misperceptions of harm remain which can compromise clinical care, research, and public health surveillance efforts. Our objective was to evaluate the empirical evidence on whether and how asking about suicide related behaviors (SRB), such as suicidal ideation and suicide attempts, and non-suicidal self-injury (NSSI) results in harmful outcomes. We reviewed and rated seventeen studies and conducted a systematic review and random-effects meta-analysis on eight studies comparing those asked vs. not asked on immediate and later SRB, NSSI, and psychological distress (PD). Forest plots demonstrated no statistically significant effects of asking on SRB, NSSI, or PD. Eight RCTs provided the strongest evidence and demonstrated either low or unclear risk of bias, and the remaining cohort studies were of low to moderate quality. With the current available evidence, we found no harmful outcomes of asking, however more RCTs with a low risk of bias are required to firmly conclude that asking through self-report and interview methods does not further exacerbate distress, SRB and NSSI compared to those not asked.

KEYWORDS

Systematic review; meta-analysis; psychological distress; suicide-related behaviors; non-suicidal self-injury

The World Health Organization considers suicide a serious public health problem and has made suicide prevention a global priority. Worldwide, there are approximately 800,000 deaths by suicide annually and an estimated 20 suicide attempts for each death by suicide (World Health Organization, 2019). As part of a suicide prevention strategy to identify those at risk for suicide, the National Institute of Mental Health encourages directly asking at risk individuals if they are thinking about killing themselves (NIMH, 2019). Few people ask, as there is fear of putting the idea in people's heads. While suicide-related behaviors (SRB) encompass both suicidal ideation (SI) and attempts (Hamza, Stewart, & Willoughby, 2012), it differs from non-suicidal self-injury (NSSI) which is defined as the destruction of body tissue without suicidal intent (Nock, 2010).

From a public health standpoint, asking about both SRB and NSSI is beneficial for many reasons including: (1) drawing attention to the magnitude of the problem, (2) examining variations in rates across groups and geographic regions, and (3) establishing local, provincial/state, and national health priorities (Data & Surveillance Task

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Force Report, 2014). Currently, rates of NSSI and SRB captured in hospital administrative databases vary and are likely underestimated (Johnson et al., 2019) as there is no gold standard for asking about these behaviors. Suicide rates are recognized as underreported, leading to further obfuscation of the issue (Kapusta et al., 2011; Pritchard & Hansen, 2015; Skinner, McFaull, Rhodes, Bowes, & Rockett, 2016). In addition, the type of items used to capture NSSI could lead to a bias in the reporting of the behavior, as the captured prevalence rates of NSSI is nearly doubled when using behavior checklists compared to single item measures (Muehlenkamp, Claes, Havertape, & Plener, 2012). Early detection, prevention and intervention efforts are necessary; however, they are limited until researchers can obtain an accurate rate of SRB, along with the associated risk and protective factors to better inform these efforts.

Not only is asking important for truly understanding and improving public health surveillance efforts, it also is important for providing clinical care. However, few seek help for NSSI and SRB, and even fewer voluntarily divulge this information. On average, 24% of adults who died by suicide had been in contact with mental health services a year beforehand (Luoma, Martin, & Pearson, 2002). Seeking help is often lower for NSSI, as approximately 23% of college students who reported NSSI did not divulge this information to anyone, and only 9% sought help from a mental health professional (Whitlock et al., 2011). Health care providers do not routinely inquire about NSSI (Taliaferro et al., 2013), or SRB (Frankenfield et al., 2000; O'Reilly, Kiyimba, & Karim, 2016; Rebair & Hulatt, 2017). Asking about SRB is often low and varies by health care settings with more mental health experience. For example, in emergency departments, rates of asking about SRB range from 34% for non-psychiatric patients to 67% for psychiatric patients (Ballard et al., 2013), by mental health practitioners (47%, O'Reilly et al., 2016), and in primary care settings (from 23% to 36%; Feldman et al., 2007; Frankenfield et al., 2000). Routinely inquiring about NSSI is also low in primary care settings (27%, Taliaferro et al., 2013).

Reasons include that some clinicians and nurses do not feel comfortable asking and do not feel knowledgeable about suicide (Bocquier et al., 2013; Quinnett, 2019; Rebair & Hulatt, 2017) or NSSI (Bajaj et al., 2008; Taliaferro et al., 2013). Similarly, teachers also report feeling less comfortable and knowledgeable about NSSI (Toste & Heath, 2010). Qualitative studies with youth indicate that the majority (80–96%) are in favor of being asked to help identify those at risk (Ballard et al., 2013; Horowitz et al., 2010; Lockwood, Townsend, Royes, Daley, & Sayal, 2018; Snyder et al., 2017). However, qualitative studies that only focus on participant or clinician perspectives do not evaluate the actual harms or benefits from asking (Ballard et al., 2013; Horowitz et al., 2010; Ross et al., 2016; Snyder et al., 2017).

Literature reviews and meta-analyses have examined the outcomes after asking about suicide (Dazzi, Gribble, Wessely, & Fear, 2014; DeCou & Schumann, 2018) and after viewing suicide related content (Blades, Stritzke, Page, & Brown, 2018). These studies concluded that no overall iatrogenic effects were found after asking or being exposed to suicide related content. However, these reviews did not include asking about NSSI or examine the effects of asking on outcomes of SRB and NSSI. Even if SRB or NSSI are asked about, the measures and methods that are used to capture these thoughts or behaviors vary, which may lead to an underrepresentation of the behavior (Berman &

Silverman, 2017; Johnson et al., 2019). Not only is it important to ask for suicide prevention efforts, but how these questions are asked and who asks also affects the participant's response (Hom, Stanley, Podlogar, & Joiner, 2017; McCabe, Sterno, Priebe, Barnes, & Byng, 2017; O'Reilly et al., 2016). However, it is unknown how asking about SRB and NSSI in various ways is associated with negative outcomes. Berman and Silverman (2017) emphasize that despite the variety of ways to ask, there is a need for empirical evidence to inform best practice of how to ask about SRB and NSSI and to operationalize the language that is used to ask the question.

To date, although three systematic reviews on iatrogenic effects of asking or being exposed to suicidality have been conducted (Blades et al., 2018; Dazzi et al., 2014; DeCou & Schumann, 2018), no systematic reviews have been found which focus on the outcomes after asking about SRB and NSSI, examining how studies asked about SRB and NSSI, and included a risk of bias and quality assessment. Assessing risk of bias is important to ensure that overall estimates of harmful outcomes are not influenced by highly biased effects.

OBJECTIVES

The objective of this systematic review was to examine the empirical evidence on the effects of asking about SRB and NSSI. We have updated and expanded upon the systematic reviews and meta analyses by DeCou and Schumann (2018) and Blades et al. (2018) by including studies that have examined quantitative outcomes after asking about SRB and NSSI. We also examined how NSSI and SRB were inquired about, and provided a rating of the quality and bias of included empirical studies. Our main research question was: Does asking about SRB or NSSI lead to harmful outcomes?

METHODS

This systematic review was registered on PROSPERO (CRD42018082517) on January 30, 2018. We followed the PRISMA harms checklist for reporting of systematic reviews and meta-analysis with harm-related outcomes (Zorzela et al., 2016; see online Supplemental materials for details of the checklist).

Search Strategy and Eligibility Criteria

The following databases were searched up to March 26, 2019 (Embase, PsycINFO, ProQuest Public Health Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R)) for studies that met our inclusion criteria:

1. Published in peer-reviewed journals
2. Empirical studies examining harms and/or benefits of asking about suicide and NSSI
3. Observational studies with a quantitative outcome
4. Studies involving only human subjects
5. Written in English and French

Exclusions included:

1. Non-peer reviewed studies
2. Dissertations
3. Qualitative studies
4. Studies published in other languages besides English and French

No restrictions were placed on age, study location, or publication date. Our search term combinations included four sets of terms related to suicide and non-SRBs, asking about the behavior, peer reviewed publications, and manuscripts published in English or French, since both are official languages in Canada (See online Supplemental materials for databases and search terms).

Risk of Bias and Quality Appraisal

Cochrane Risk of Bias Tool

The Cochrane Risk of Bias tool (Higgins et al., 2011) was used to rate the risk of bias of the results of the 8 included studies that used randomization to an experimental group (being asked about SRB or NSSI) and a control group who was not asked (Bjärehed, Pettersson, Wangby-Lundh, & Lundh, 2013; Crawford et al., 2011; de Beurs, Ghoncheh, Geraedts, & Kerkhof, 2016; Gould et al., 2005; Harris & Goh, 2017; Law et al., 2015; Muehlenkamp, Swenson, Batejan, & Jarvi, 2015; Robinson et al., 2011). We decided to include the Bjärehed et al. (2013) study in the Risk of Bias assessment as they used randomization from matched NSSI/no NSSI subsets for the experimental interview and non-interview control group, despite inquiring about NSSI before the interview.

Two authors (CP and RS) independently rated several areas of bias, and this accounted for 56 individual ratings for the 8 overall studies. Any discrepancies were independently and blindly reviewed (PC) and were resolved. The raters discussed the rating components beforehand along with the sections of the training manual prior to rating the studies. In addition, an excel sheet with the rating instructions was set up for both raters based on the manual, to consistently rate the same information. Raters referred to the online Cochrane Manual (Higgins & Green, 2011), but did not receive any formal training on the tool since the manual and training module were available online. The several areas of study bias that could be rated as either low, unclear, or high risk based on:

1. Selection bias: random sequence generation
2. Selection bias: allocation concealment
3. Reporting bias: selective reporting
4. Other bias
5. Performance bias: blinding participants and personnel
6. Detection bias: blinding (outcome assessment)
7. Attrition bias: incomplete outcome data

We summarized within studies and across studies based upon the proportion of low, unclear, and high risk of bias (Higgins & Green, 2011). Within study assessments were rated as: Low risk (all domains were rated as low), high risk (one or more domains

were rated as high risk), and unclear (one or more domains were unclear). Across studies, bias was rated as unclear if most of the information was low or unclear. Ratings of low were administered if low ratings were 5 or greater across the 8 studies.

Newcastle-Ottawa Quality Assessment Tool

The Newcastle-Ottawa tool (Wells et al., 2000) was used to assess the quality of non-randomized studies, which included longitudinal cohort and case-control studies. Three areas were awarded stars for cohort studies, which included:

1. Selection (4 stars)
2. Comparability (2 stars)
3. Outcome (3 stars)

The areas that were awarded stars in Selection included four areas:

1. Representativeness of the intervention cohort (true or somewhat representative of the average individual that is asked)
2. Selection of the nonintervention cohort (drawn from the same community as the intervention cohort)
3. Ascertainment of intervention questions/exposure (health care record or through structured interview with a clinician)
4. Demonstration that each outcome of interest was not present at the beginning of the study

Comparability was rated as the comparability between two cohorts in:

1. Demographic variables (1 star)
2. Other areas (1 star)

Outcome included three areas:

1. Assessment of outcomes (1 star awarded for independent blind assessment or through record linkage)
2. Follow-up of the outcome was long enough to occur (1 star awarded if measured immediately after being asked to prevent influence of extraneous variables)
3. Adequacy of follow-up cohorts (1 star awarded if no drop out/all subjects accounted for, or if subjects were lost to follow-up were below 20% and were unlikely to introduce bias)

A study could have been awarded 9 stars in total, where a total score from 7 to 9 indicates high quality, 4–6 as moderate quality, and 0–3 as low quality.

Data Analysis

The risk of bias for eight studies included one low risk of bias (Crawford et al., 2011), two were rated as high risk of bias (Bjärehed et al., 2013; de Beurs et al., 2016), and the

remaining 5 were rated as unclear (Table 1). These low and unclear ratings were included in the average meta-analysis effects below. Cohort studies received total scores between 0 and 3, which indicated low quality (Table 2). One case-control study (Table 3) received a moderate quality rating of 5/9 (Rivlin, Marzano, Hawton, & Fazel, 2012). The quality assessment ratings below were also included in the narrative review.

Assessment of Heterogeneity for Meta-Analysis

To compare the outcomes of PD, SRB, and NSSI in a meta-analysis, we examined how each intervention group was asked about NSSI or SRB, the outcomes of the studies, statistical methods used and completeness of data reported. Due to heterogeneity of samples included, measures used to ask about the intervention of SRB and NSSI, as well as the various continuous and dichotomous outcomes of SRB, NSSI, and PD, we found that a random effects meta-analysis was suitable for studies that had a comparison group that was not asked. For studies that reported either continuous or dichotomous outcomes, we report the standardized mean difference (SMD). The SMD was calculated in RevMan 5.3 (Review Manager (RevMan), 2014) for continuous outcomes by entering in the reported means, standard deviations and total N's in each group. For dichotomous outcomes, we used the online meta-analysis effect size calculator (Wilson, 2019) by entering in the proportions or events and total N's for each group. For some studies that did not include a total N for each group (Law et al., 2015), odds ratios were converted to *d*'s by using the equation provided by Borenstein, Hedges, Higgins, and Rothstein (2009). These effect sizes with their standard errors were then entered into RevMan 5.3. Heterogeneity across studies was assessed using the I^2 statistic in our meta-analysis, which a score over 50% indicates there is considerable heterogeneity between the included study results (Higgins, Thompson, Deeks, & Altman, 2003). We used age as a moderator, comparing studies that included youth or adults. We did not conduct a meta-analysis for studies that report pre to post mean difference effects, as they may result in biased effects due to external influence between time points (Cuijpers, Weitz, Cristea, & Twisk, 2017).

Forest plots of SRB, PD, and NSSI outcomes that report continuous (means and standard deviations) and dichotomous (frequencies) outcomes were only reported for two or more studies that compare those who were asked to those who were not asked. To avoid including the same cohorts in each analysis, we reported separate plots for studies that examined both immediate outcomes and outcomes that occurred at a later point in time. Finally, we also included separate plots for similar vulnerable samples who were asked and who were not asked.

RESULTS

Study Screening and Selection

A PRISMA diagram (Moher, Liberati, Tetzlaff, Altman, & PRISMA Group, 2009) outlines the process of conducting our three searches to ensure the included studies were up to date (Figure 1). Records were identified through several databases and after duplicates were removed, record abstracts were screened in Distiller SR (Evidence Partners,

TABLE 1. Ratings on the Cochrane Risk of Bias tool for studies using randomization

	Selection		Performance	Detection	Attrition	Reporting	Other	
	(A) Random sequence generation – reported how randomization was conducted	(B) Allocation concealment – reported how groups were concealed	(C) Blinding participants and personnel – Participants were blind	(D) Blinding (outcome assessment) – outcome assessment was blind	(E) Incomplete outcome data	(F) Selective reporting	(G) Other bias	Within study assessment
Crawford et al. (2011)	+	+	+	+	+	+	+	+
Robinson et al. (2011)	+	+	+	?	?	+	+	?
Muehlenkamp et al. (2015)	+	?	+	+	?	+	+	?
Law et al. (2015)	?	?	?	?	+	+	+	?
Harris & Goh (2017)	?	?	+	+	?	?	+	?
Gould et al. (2005)	?	?	?	?	+	+	+	?
Bjärehed et al. (2013)	?	?	–	–	?	?	+	–
de Beurs et al. (2016)	+	+	+	?	?	–	?	–
Across Study Assessment	+	?	+	?	?	+	+	

Note. + = Low risk of bias, - = High risk of bias, ? = Unclear.

TABLE 2. Ratings on the Newcastle-Ottawa for observational cohort studies.

	Selection				Comparability	Outcome			
Cohort	Representativeness of exposed cohort	Selection of non-exposed cohort	Ascertainment of exposure	Outcome not present at baseline	Cohorts matched for (at least 2 items)	Assessment of outcome	Sufficient follow-up duration	Adequate follow-up	Total score
Deeley and Love (2010)	*						*	*	3
Eynan et al. (2014)			*			*		*	3
Lockwood et al. (2018)	*						*	*	3
Reynolds et al. (2006)			*				*	*	3
Bailey et al. (2017)	*						*		2
Biddle et al. (2013)							*	*	2
Hom et al. (2018)	*						*		2
Mathias et al. (2012)									0

Note. * = Star awarded.

TABLE 3. Ratings on the Newcastle-Ottawa for case control studies.

	Selection			Comparability		Exposure			
Case-control	Independent validation	Representativeness of cases	Selection of controls	No history of outcome	Cases and controls matched for	Ascertainment of exposure	Method of ascertainment	Non-response rate	Total Score
Rivlin et al. (2012)	*		*		** (Age, prison type)		*		5

Note: * = Star awarded

Ottawa, Canada) by JK and PC. Records were excluded if they did not meet inclusion criteria (not related to the study question). Full text articles were assessed for eligibility by two independent raters. After review of the full text quantitative and qualitative studies, we excluded studies that did not include quantitative outcomes from being asked (i.e., qualitative methods only, reviews, editorials, etc.). Overall, a total of 13 articles were included in the first search, two articles (Bailey, Spittal, Pirkis, Gould, & Robinson, 2017; Rivlin et al., 2012) were included as a result of the second search, and two articles were included from the third search, including one on outcomes of NSSI (Lockwood et al., 2018) and one on repeated suicidality screening (Hom et al., 2018).

We also found the systematic reviews and meta-analysis by DeCou and Schumann (2018) and Blades et al. (2018). After conducting a hand search of these references we extracted the Rivlin et al. (2012) article from reviewing the DeCou and Schumann references. No full text studies were extracted from Blades et al. as they did not specifically look at outcomes after being asked.

Study Characteristics

Seventeen studies assessed participants who were asked and eight of these studies compared outcomes to participants who were not asked, which were included in the meta-analysis (Bjärehed et al., 2013; Crawford et al., 2011; de Beurs et al., 2016; Gould et al., 2005; Harris & Goh, 2017; Law et al., 2015; Muehlenkamp et al., 2015; Robinson et al., 2011). Table 4 includes a summary of the characteristics of the studies included in the systematic review, meta-analysis, and narrative review. See online supplement for a detailed list of study characteristics.

All studies included a lead up of measures prior to asking about SRB and NSSI, with the exception of Lockwood et al. (2018). Ten studies used self-report questionnaires, either provided on an electronic device (de Beurs et al., 2016; Harris & Goh, 2017; Law et al., 2015; Muehlenkamp et al., 2015; Robinson et al., 2011) or on paper (Bailey et al., 2017; Deeley & Love, 2010; Gould et al., 2005; Hom et al., 2018; Lockwood et al., 2018; Mathias et al., 2012). Five included an interview and a self-report (Bjärehed et al., 2013; Eynan et al., 2014; Reynolds, Lindenboim, Comtois, Murray, & Linehan, 2006; Rivlin et al., 2012), and two used an in-person or telephone interview only (Biddle et al., 2013; Crawford et al., 2011). All studies consistently reported including safeguards prior to asking and/or after asking. See online supplement for the reported questions that were asked.

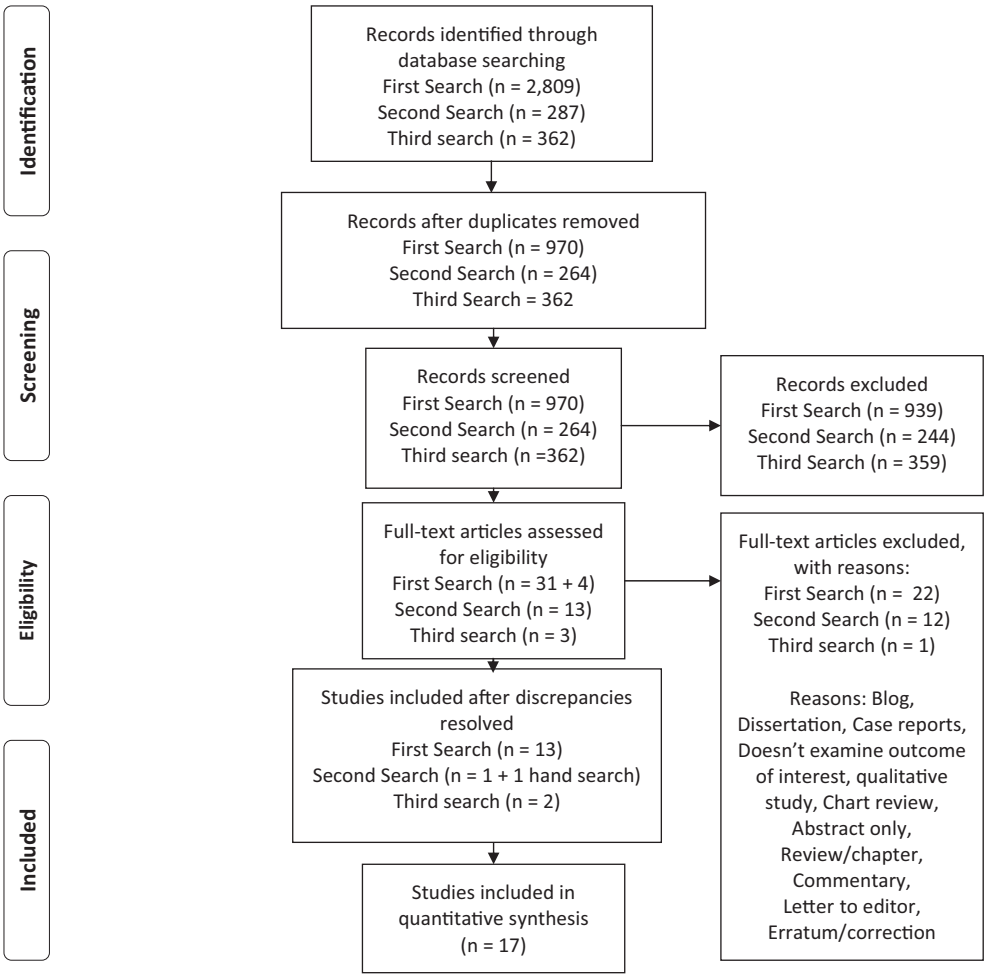
Identification
Screening
Eligibility
Included
Records identified through database searching
First Search (n = 2,809)
Second Search (n = 287)
Third search (n = 362)
Records after duplicates removed
First Search (n = 970)
Second Search (n = 264)
Third Search = 362
Records screened
First Search (n = 970)
Second Search (n = 264)
Third search (n =362)
Records excluded
First Search (n = 939)
Second Search (n = 244)
Third Search (n = 359)
Full-text articles assessed for eligibility
First Search (n = 31 + 4)
Second Search (n = 13)
Third search (n = 3)
Full-text articles excluded, with reasons:
First Search (n = 22)
Second Search (n = 12)
Third search (n = 1)
Reasons: Blog, Dissertation, Case reports, Doesn't examine outcome of interest, qualitative study, Chart review, Abstract only, Review/chapter, Commentary, Letter to editor, Erratum/correction
Studies included after discrepancies resolved
First Search (n = 13)
Second Search (n = 1 + 1 hand search)
Third search (n = 2)
Studies included in quantitative synthesis
(n = 17)

Figure 1. PRISMA flow diagram.

Meta-Analysis

We conducted meta-analyses in RevMan5.3 (Review Manager (RevMan), 2014) for studies that had both a group that was asked and a group that was not asked. Table 5 includes a summary of the studies eligible for the meta-analysis for each reported outcome and those eligible for the narrative review. Quantitative outcomes that were reported for studies with a control group included: Mortality (Law et al., 2015), suicide attempts (Crawford et al., 2011; Law et al., 2015), suicidal ideation (Crawford et al., 2011; Gould et al., 2005; Law et al., 2015), psychological distress (de Beurs et al., 2016; Gould et al., 2005; Harris & Goh, 2017; Law et al., 2015; Muehlenkamp et al., 2015; Robinson et al., 2011), NSSI events (Bjärehed et al., 2013; Law et al., 2015; Muehlenkamp et al., 2015) and NSSI urges (Muehlenkamp et al., 2015). Unfortunately, there were not enough study outcomes reported to include mortality, suicide attempts, or NSSI urges in the meta-analysis or for vulnerable samples of borderline personality disorder, substance use, suicide risk, or NSSI history/engagement. All overall meta-

TABLE 4. Systematic review study characteristics.

Systematic review study characteristics ($N = 17$)	RCT/experimental studies with control group who was not asked $n = 8$	Cohort/case-control studies $n = 9$
Sample Age	47% (8)	53% (9)
Youth ($n = 7$)	43% (3)	57% (4)
Adult ($n = 9$)	40% (4)	50% (5)
Mixed youth and adult ($n = 1$)	100% (1)	0
Sample setting	47% (8)	53% (9)
Community ($n = 3$)	100% (3)	0
School ($n = 8$)	50% (4)	50% (4)
Mixed school and community ($n = 2$)	50% (1)	50% (1)
Clinical ($n = 4$)	0	100% (4)
Vulnerable samples ($n = 5$)	20% (1)	80% (4)
Depression ($n = 1$)	100% (1)	0
Psychiatric inpatients/inpatient history ($n = 2$)	0	100% (2)
Suicidal ideation/attempt history ($n = 2$)	0	100% (2)
Vulnerable sub-samples ($n = 9$*)	7	4
Personality disorders ($n = 2$)	50% (1)	50% (1)
NSSI ($n = 3$)	50% (2)	50% (1)
Depression/emotional ($n = 3$)	100% (3)	0
Substance use ($n = 1$)	100% (1)	0
Suicide risk ($n = 3$)	33% (1)	66% (2)
Outcomes		
Psychological distress ($n = 13$)	46% (6)	54% (7)
SRB ($n = 8$)	38% (3)	62% (5)
NSSI events ($n = 3$)	100% (3)	0
NSSI urges ($n = 2$)	50% (1)	50% (1)
Mortality ($n = 1$)	100% (1)	0
Asking intervention		
SRB only ($n = 9$)	66% (6)	33% (3)
NSSI only ($n = 3$)	66% (2)	33% (1)
Both SRB and NSSI ($n = 4$)	0	100% (4)

*Nine studies total, although some studies examined effects of asking in more than 1 sub-sample.

analysis effect sizes were below .30, which is considered a small effect size (Borenstein et al., 2009).

Psychological Distress

While PD was the most commonly measured subjective outcome reported in 13 of 17 studies (Bailey et al., 2017; Biddle et al., 2013; de Beurs et al., 2016; Deeley & Love, 2010; Gould et al., 2005; Harris & Goh, 2017; Hom et al., 2018; Law et al., 2015; Lockwood et al., 2018; Muehlenkamp et al., 2015; Reynolds et al., 2006; Rivlin et al., 2012; Robinson et al., 2011), there were only four or fewer studies that contributed to the PD meta-analysis effect. Six studies compared outcomes of immediate PD between control and experimental groups (de Beurs et al., 2016; Gould et al., 2005; Harris & Goh, 2017; Law et al., 2015; Muehlenkamp et al., 2015; Robinson et al., 2011) and included ratings of high and unclear risk of bias (Figure 2). We removed one study with a high risk of bias from contributing to the overall average effect (de Beurs et al., 2016), and one study did not provide sufficient information for the PD effect to be calculated (Law et al., 2015). Four of the remaining studies (two youth and two adult

samples) with an unclear risk of bias rating, contributed to the overall small non-significant effect of immediate PD (Figure 2). There was considerable variability between the effect sizes of the two subgroups ($I^2 = 70.3\%$) and in the overall effect size ($I^2 = 71\%$). In terms of *how* they were asked, all studies included in the PD meta-analysis effect had asked about SRB and NSSI by using different self-report measures in school and in community settings. See online Supplemental material for the reported questions that were asked.

Two studies (one youth and one adult from school and community settings) with an unclear risk of bias rating contributed to the significant negative effect of immediate PD among participants with depression (Gould et al., 2005; Harris & Goh, 2017), where immediate PD was significantly lower in those with depression who were asked about SRB using self-report measures compared to those not asked (Figure 3). There was no heterogeneity in the effect sizes ($I^2 = 0\%$), indicating the two effect sizes were consistent.

Suicide Related Behaviors

The second most common outcome measure was SRB, as measured by suicide attempts and suicide ideation in 8 of 17 studies (Bailey et al., 2017; Crawford et al., 2011; Eynan et al., 2014; Gould et al., 2005; Hom et al., 2018; Law et al., 2015; Mathias et al., 2012; Reynolds et al., 2006) and only two studies contributed to an overall effect of suicidal ideation (Gould et al., 2005; Law et al., 2015). Two studies (including one youth and one adult sample from either school or community settings) both with an unclear risk of bias, contributed to the non-significant effect of immediate SI (Figure 4) and later SI (Figure 5). There was no heterogeneity in the immediate and later effect sizes ($I^2 = 0\%$), indicating the two effect sizes were consistent. Both studies included self-report measures to ask about SRB. Two studies (Crawford et al., 2011; Gould et al., 2005) with a low and unclear risk of bias contributed to a non-significant effect of later SI for individuals with depression (Figure 6). There was some variability in the overall ($I^2 = 22\%$) and subgroup effects ($I^2 = 21.7\%$), as one study (Gould et al., 2005) asked youth by self-report measures while the other asked a mixed youth and adult sample by a telephone interview (Crawford et al., 2011).

Non-Suicidal Self-Injury

Outcomes of NSSI were examined in four studies (Bjärehed et al., 2013; Eynan et al., 2014; Law et al., 2015; Muehlenkamp et al., 2015) and three of these studies compared outcomes of NSSI between experimental and control groups who were not asked (Bjärehed et al., 2013; Law et al., 2015; Muehlenkamp et al., 2015). Since Bjärehed et al. (2013) was rated as having a high risk of bias, this individual effect was not included in the overall meta-analysis effect. Two studies included adult samples from school or community settings and were rated as having an unclear risk of bias. The two individual effects contributed to a small non-significant effect for later NSSI events (Law et al., 2015; Muehlenkamp et al., 2015) and were consistent ($I^2 = 0\%$; Figure 7). Both of these studies asked using different self-report measures in either school or community settings.

TABLE 5. Summary of study effects eligible for the meta-analysis and narrative review.

Study	Sample	Setting	How they asked	Outcomes: Psychological/ emotional distress Immed.	Psychological/ emotional distress Later	Suicide- related behavior Immed.	Suicide- related behavior Later	NSSI events Immed.	NSSI events Later	NSSI urge Later	Mortality Later
RCT / Experimental											
Bjärehed et al., 2013	Youth	Community	Interview & self-report					◆○[d]	◆○[d]		
Gould et al., 2005	Youth	School	Self-report	◆●[a]○[bc]	◆○[abc]	◆○[abc]	◆●[a]○[bc]				
Robinson et al., 2011	Youth	School	Self-report	◆○[c]							
Crawford et al., 2011	Youth & Adult	Community	Interview				◆[a] ○[e]				
de Beurs et al., 2016	Adult	School	Self-report	◆							
Harris & Goh, 2017	Adult	School & community	Self-report	◆●[a]○[c]							
Law et al., 2015	Adult	Community	Self-report	□○[e]	□○[e]	□◆○[e]	□◆○[e]	◆○[e]	◆○[e]		□
Muehlenkamp et al., 2015	Adult	School	Self-report	◆○[d]					◆○[d]	○[d]	
Cohort / Case control											
Bailey et al., 2017	Youth	School	Self-report	□	□	□	□				
Deeley & Love, 2010	Youth[e]	School & community	Self-report	□○[c]	□○[c]						
Lockwood et al., 2018	Youth	School	Self-report	□○[d]	□○[d]						
Mathias et al., 2012	Youth	Clinical	Self-report				□[c]				
Biddle et al., 2013	Adult	School	Interview	□							
Eynan et al., 2014	Adult	Clinical	Interview & self-report				□[c]		□	□[c]	
Hom et al., 2018	Adult	School	Self-report		□		□				
Reynolds et al., 2006	Adult	Clinical	Interview & self-report		□[c]		□[c]				
Rivlin et al., 2012	Adult	Clinical/ institutional	Interview & self-report	□○[c]							

Inclusion in meta-analysis effect: ◆ All participants, ● subsamples.
Eligible for narrative review: □ All participants, ^ subsamples.
Vulnerable groups: [a]depression, [b]substance use, [c]suicide risk, [d]NSSI, [e]personality disorder.

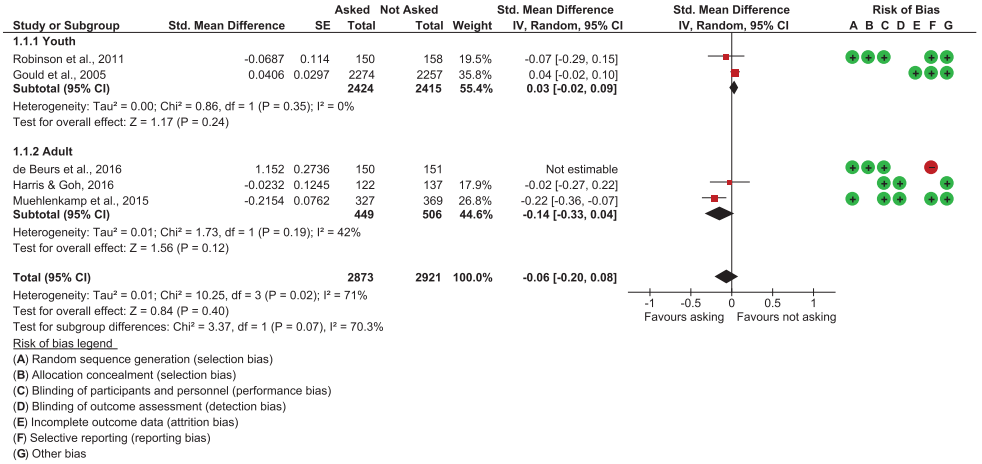
Asked Not Asked Std. Mean Difference Std. Mean Difference Risk of Bias
Study or Subgroup Std. Mean Difference SE Total Total Weight IV, Random, 95% CI IV, Random, 95% CI A B C D E F G
1.1.1 Youth
Robinson et al., 2011 -0.0687 0.114 150 158 19.5% -0.07 [-0.29, 0.15]
Gould et al., 2005 0.0406 0.0297 2274 2257 35.8% 0.04 [-0.02, 0.10]
Subtotal (95% CI) 2424 2415 55.4% 0.03 [-0.02, 0.09]
Heterogeneity: Tau² = 0.00; Chi² = 0.86, df = 1 (P = 0.35); I² = 0%
Test for overall effect: Z = 1.17 (P = 0.24)
1.1.2 Adult
de Beurs et al., 2016 1.152 0.2736 150 151 Not estimable
Harris & Goh, 2016 -0.0232 0.1245 122 137 17.9% -0.02 [-0.27, 0.22]
Muehlenkamp et al., 2015 -0.2154 0.0762 327 369 26.8% -0.22 [-0.36, -0.07]
Subtotal (95% CI) 449 506 44.6% -0.14 [-0.33, 0.04]
Heterogeneity: Tau² = 0.01; Chi² = 1.73, df = 1 (P = 0.19); I² = 42%
Test for overall effect: Z = 1.56 (P = 0.12)
Total (95% CI) 2873 2921 100.0% -0.06 [-0.20, 0.08]
Heterogeneity: Tau² = 0.01; Chi² = 10.25, df = 3 (P = 0.02); I² = 71%
Test for overall effect: Z = 0.84 (P = 0.40)
Test for subgroup differences: Chi² = 3.37, df = 1 (P = 0.07), I² = 70.3%
-1 -0.5 0 0.5 1
Favours asking Favours not asking
Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Figure 2. Average effect of Immediate distress for all participants.

Overall, our meta-analysis results indicate that asking school and community samples about SRB and NSSI using self-report methods does not result in harmful outcomes of PD, SI, and NSSI. However fewer than five studies out of the 17 studies that we reviewed contributed to these results. While the overall effect of immediate PD was significantly lower in samples with depression who were asked compared to those who were not asked, only two studies contributed to this effect. More empirical studies with a low risk of bias are needed that: (1) utilize verbal methods of asking about SRB and NSSI, (2) include clinical samples, and (3) include a control group.

Narrative Synthesis of Cohort and Case-Control Studies

We provide a narrative review of the nine cohort and case-control studies with no comparison group who was not asked, as there was quantitative information available on the outcomes of asking about suicide and self-harm (Bailey et al., 2017; Biddle et al., 2013; Deeley & Love, 2010; Eynan et al., 2014; Hom et al., 2018; Lockwood et al., 2018; Mathias et al., 2012; Reynolds et al., 2006; Rivlin et al., 2012).

Seven low to moderate quality rated cohort studies examined either mean changes, rates of change, or change proportions in outcomes of PD over time (Bailey et al., 2017; Biddle et al., 2013; Deeley & Love, 2010; Hom et al., 2018; Lockwood et al., 2018; Reynolds et al., 2006; Rivlin et al., 2012). While six studies reported some increase in participants with PD after participating (Bailey et al., 2017; Biddle et al., 2013; Deeley & Love, 2010; Lockwood et al., 2018; Reynolds et al., 2006; Rivlin et al., 2012), all seven studies mentioned the majority of participants experienced decreases or no changes in PD over time. Of these studies, only three asked verbally using an interview (Biddle et al., 2013) or using both interviews and self-report measures (Reynolds et al., 2006; Rivlin et al., 2012), and four studies used self-report measures (Bailey et al., 2017; Deeley & Love, 2010; Hom et al., 2018; Lockwood et al., 2018).

Five cohort studies that were rated as low quality examined changes in SRB (Bailey et al., 2017; Eynan et al., 2014; Hom et al., 2018; Mathias et al., 2012; Reynolds et al.,

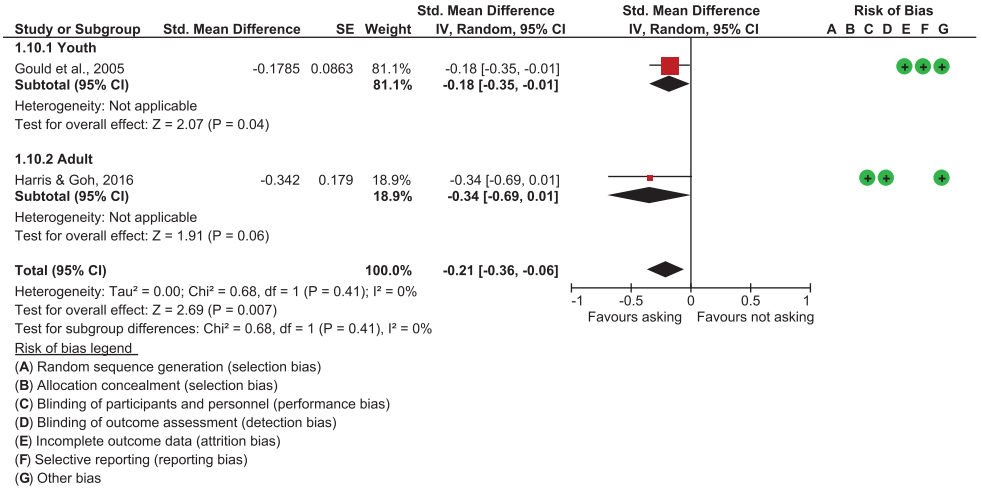
Std. Mean Difference
Std. Mean Difference
Risk of Bias
Study or Subgroup Std. Mean Difference SE Weight IV, Random, 95% CI
IV, Random, 95% CI
A B C D E F G
1.10.1 Youth
Gould et al., 2005 -0.1785 0.0863 81.1% -0.18 [-0.35, -0.01]
Subtotal (95% CI) 81.1% -0.18 [-0.35, -0.01]
Heterogeneity: Not applicable
Test for overall effect: Z = 2.07 (P = 0.04)
1.10.2 Adult
Harris & Goh, 2016 -0.342 0.179 18.9% -0.34 [-0.69, 0.01]
Subtotal (95% CI) 18.9% -0.34 [-0.69, 0.01]
Heterogeneity: Not applicable
Test for overall effect: Z = 1.91 (P = 0.06)
Total (95% CI) 100.0% -0.21 [-0.36, -0.06]
Heterogeneity: Tau² = 0.00; Chi² = 0.68, df = 1 (P = 0.41); I² = 0%
Test for overall effect: Z = 2.69 (P = 0.007)
Test for subgroup differences: Chi² = 0.68, df = 1 (P = 0.41), I² = 0%
-1 -0.5 0 0.5 1
Favours asking Favours not asking
Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Figure 3. Average effect of immediate distress for those with depression.

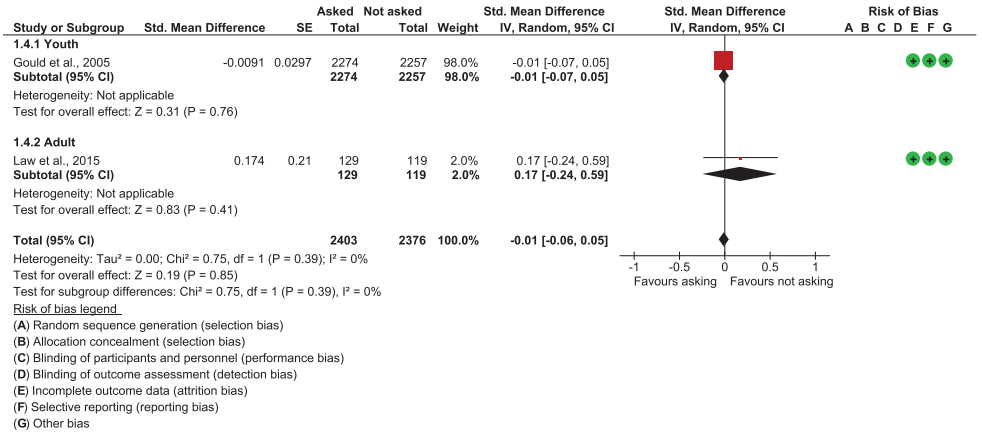
Asked Not asked
Std. Mean Difference
Std. Mean Difference
Risk of Bias
Study or Subgroup Std. Mean Difference SE Total Total Weight IV, Random, 95% CI
IV, Random, 95% CI
A B C D E F G
1.4.1 Youth
Gould et al., 2005 -0.0091 0.0297 2274 2257 98.0% -0.01 [-0.07, 0.05]
Subtotal (95% CI) 2274 2257 98.0% -0.01 [-0.07, 0.05]
Heterogeneity: Not applicable
Test for overall effect: Z = 0.31 (P = 0.76)
1.4.2 Adult
Law et al., 2015 0.174 0.21 129 119 2.0% 0.17 [-0.24, 0.59]
Subtotal (95% CI) 129 119 2.0% 0.17 [-0.24, 0.59]
Heterogeneity: Not applicable
Test for overall effect: Z = 0.83 (P = 0.41)
Total (95% CI) 2403 2376 100.0% -0.01 [-0.06, 0.05]
Heterogeneity: Tau² = 0.00; Chi² = 0.75, df = 1 (P = 0.39); I² = 0%
Test for overall effect: Z = 0.19 (P = 0.85)
Test for subgroup differences: Chi² = 0.75, df = 1 (P = 0.39), I² = 0%
-1 -0.5 0 0.5 1
Favours asking Favours not asking
Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Figure 4. Average effect of immediate suicidal ideation for all participants.

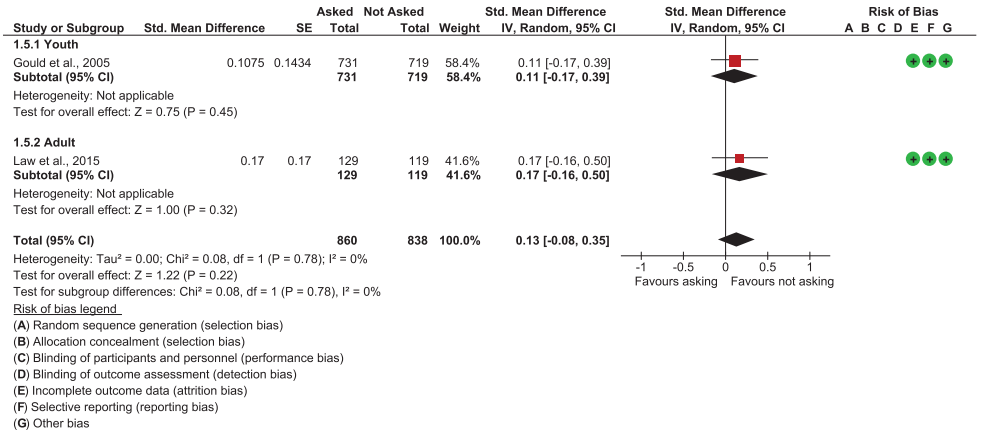
Asked Not Asked
Std. Mean Difference
Std. Mean Difference
Risk of Bias
Study or Subgroup Std. Mean Difference SE Total Total Weight IV, Random, 95% CI
IV, Random, 95% CI
A B C D E F G
1.5.1 Youth
Gould et al., 2005 0.1075 0.1434 731 719 58.4% 0.11 [-0.17, 0.39]
Subtotal (95% CI) 731 719 58.4% 0.11 [-0.17, 0.39]
Heterogeneity: Not applicable
Test for overall effect: Z = 0.75 (P = 0.45)
1.5.2 Adult
Law et al., 2015 0.17 0.17 129 119 41.6% 0.17 [-0.16, 0.50]
Subtotal (95% CI) 129 119 41.6% 0.17 [-0.16, 0.50]
Heterogeneity: Not applicable
Test for overall effect: Z = 1.00 (P = 0.32)
Total (95% CI) 860 838 100.0% 0.13 [-0.08, 0.35]
Heterogeneity: Tau² = 0.00; Chi² = 0.08, df = 1 (P = 0.78); I² = 0%
Test for overall effect: Z = 1.22 (P = 0.22)
Test for subgroup differences: Chi² = 0.08, df = 1 (P = 0.78), I² = 0%
-1 -0.5 0 0.5 1
Favours asking Favours not asking
Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Figure 5. Average effect of later suicidal ideation for all participants.

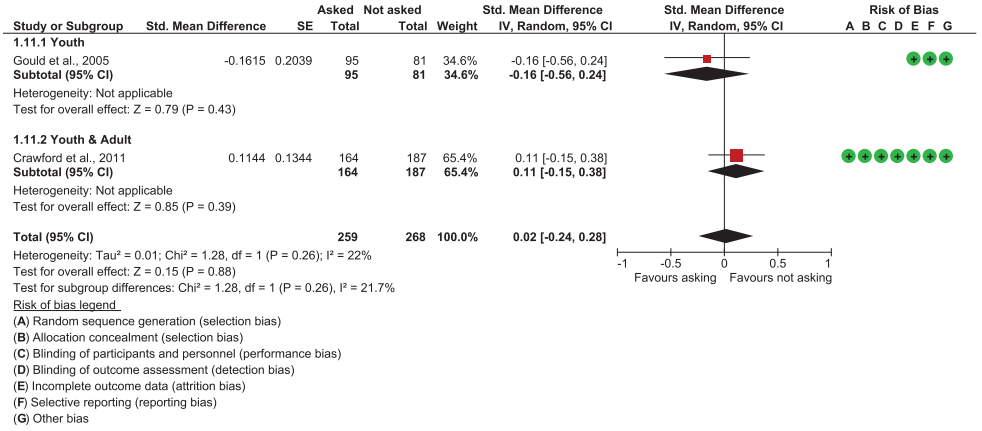
Asked Not asked Std. Mean Difference Std. Mean Difference Risk of Bias
Study or Subgroup Std. Mean Difference SE Total Total Weight IV, Random, 95% CI IV, Random, 95% CI A B C D E F G
1.11.1 Youth
Gould et al., 2005 -0.1615 0.2039 95 81 34.6% -0.16 [-0.56, 0.24]
Subtotal (95% CI) 95 81 34.6% -0.16 [-0.56, 0.24]
Heterogeneity: Not applicable
Test for overall effect: Z = 0.79 (P = 0.43)
1.11.2 Youth & Adult
Crawford et al., 2011 0.1144 0.1344 164 187 65.4% 0.11 [-0.15, 0.38]
Subtotal (95% CI) 164 187 65.4% 0.11 [-0.15, 0.38]
Heterogeneity: Not applicable
Test for overall effect: Z = 0.85 (P = 0.39)
Total (95% CI) 259 268 100.0% 0.02 [-0.24, 0.28]
Heterogeneity: Tau² = 0.01; Chi² = 1.28, df = 1 (P = 0.26); I² = 22%
Test for overall effect: Z = 0.15 (P = 0.88)
Test for subgroup differences: Chi² = 1.28, df = 1 (P = 0.26), I² = 21.7%
-1 -0.5 0 0.5 1
Favours asking Favours not asking
Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Figure 6. Average effect of later suicidal ideation for those with depression.

2006). Although three studies with high risk clinical samples reported an increase in SRB over time for some participants (Eynan et al., 2014; Mathias et al., 2012; Reynolds et al., 2006), all studies reported the majority of participants either had decreased or there was no change in SRB after being asked, indicating that SRB can be asked about safely even in high-risk samples (Eynan et al., 2014; Mathias et al., 2012; Reynolds et al., 2006). Of the five studies, two asked using interviews and self-report measures (Eynan et al., 2014; Reynolds et al., 2006) and three asked using self-report measures (Bailey et al., 2017; Hom et al., 2018; Mathias et al., 2012).

Of the cohort studies that examined outcomes of NSSI events and urge (Eynan et al., 2014), the majority of suicidal participants reported no changes in self harm urge. A small proportion with moderate/severe NSSI reported an increased urge to self-harm, and those who required intervention also reported more NSSI events.

DISCUSSION

The current state of the literature demonstrates that directly asking about SRB and NSSI through self-reports does not result in overall harmful outcomes of PD, SRB, and NSSI compared to those who are not asked. Asking may even benefit youth emotionally from the discussion with health professionals (Ross et al., 2016), as indicated by significantly lower PD for those with depression who were asked. Overall, the meta-analysis is representative of community and school based samples, and clinical samples were represented in the narrative review. Most of the cohort studies were of low quality as there were no control groups who were not asked and most included a time frame whereby other influences may have affected the outcome. Changes in these outcomes measured at a later point in time should be interpreted with caution, since it was unknown whether these changes in harmful outcomes for some participants were due to asking repeatedly or from other unmeasured stressful life events (Deeley & Love, 2010; Harris & Goh, 2017; Lockwood et al., 2018; Mathias et al., 2012; Muehlenkamp et al., 2015; Reynolds et al., 2006).

While our systematic review and meta-analysis results did not examine how to start a conversation about SRB or NSSI, it is important for SRB and NSSI to be asked

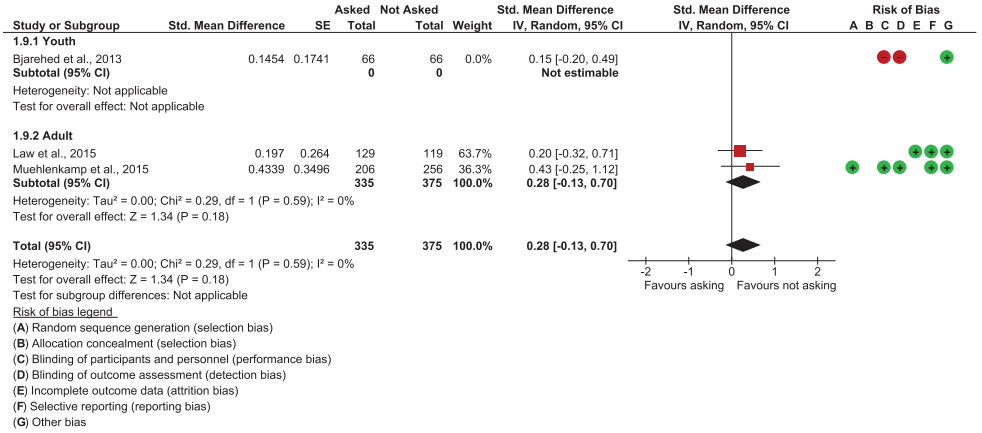
Asked
Not Asked
Std. Mean Difference
Std. Mean Difference
Risk of Bias
Study or Subgroup
Std. Mean Difference
SE
Total
Total
Weight
IV, Random, 95% CI
IV, Random, 95% CI
A B C D E F G
1.9.1 Youth
Bjarehed et al., 2013 0.1454 0.1741 66 66 0.0% 0.15 [-0.20, 0.49]
Subtotal (95% CI) 0 0 Not estimable
Heterogeneity: Not applicable
Test for overall effect: Not applicable
1.9.2 Adult
Law et al., 2015 0.197 0.264 129 119 63.7% 0.20 [-0.32, 0.71]
Muehlenkamp et al., 2015 0.4339 0.3496 206 256 36.3% 0.43 [-0.25, 1.12]
Subtotal (95% CI) 335 375 100.0% 0.28 [-0.13, 0.70]
Heterogeneity: Tau² = 0.00; Chi² = 0.29, df = 1 (P = 0.59); I² = 0%
Test for overall effect: Z = 1.34 (P = 0.18)
Total (95% CI) 335 375 100.0% 0.28 [-0.13, 0.70]
Heterogeneity: Tau² = 0.00; Chi² = 0.29, df = 1 (P = 0.59); I² = 0%
Test for overall effect: Z = 1.34 (P = 0.18)
Test for subgroup differences: Not applicable
-2
-1
0
1
2
Favours asking
Favours not asking
Risk of bias legend
(A) Random sequence generation (selection bias)
(B) Allocation concealment (selection bias)
(C) Blinding of participants and personnel (performance bias)
(D) Blinding of outcome assessment (detection bias)
(E) Incomplete outcome data (attrition bias)
(F) Selective reporting (reporting bias)
(G) Other bias

Figure 7. Average effect of later non-suicidal self-injury.

consistently, empathically, and safely. Even though validated and reliable clinician administered tools [e.g., Ask Suicide Screening Questions (Horowitz et al., 2012, 2013)], Columbia-Suicide Severity Rating Scale (Posner et al., 2011) and clinical interviews exist [e.g., Self-Injurious Thoughts and Behaviors Interview (Nock, Holmberg, Photos, & Michel, 2007)], training and comfort with screening tools and discussing suicidality or NSSI remains an issue (Horowitz et al., 2013). Comfort with starting a conversation about suicide is higher when training is provided in how to help a person who is feeling suicidal (Jorm, Nicholas, Pirkis, Rossetto, & Reavley, 2018; Silva, Smith, Dodd, Covington, & Joiner, 2016; Smith, Silva, Covington, & Joiner, 2014), or when tools are routinely used to help guide the questions to ask and what to do afterwards (Horowitz et al., 2013; Roush et al., 2018). One example in Canada which helps health care professionals to gain the confidence to talk about suicide includes an online accredited suicide prevention module offered by The Mental Health Commission of Canada (2020). Additionally, Mental Health First Aid training courses are available in over 20 countries to help all people toward how to start a conversation about suicide and NSSI, how to offer initial help, and when to guide a person toward seeking professional help. These courses are based on a set of guidelines that have been recently re-developed in 2018 by a panel of mental health, carer, and public consumer experts specifically for mental health crisis situations, including SRB (Ross, Kelly, & Jorm, 2014a) and NSSI (Ross, Kelly, & Jorm, 2014b). The guidelines are available in the public domain for how to help someone who is thinking about suicide (Mental Health First Aid Australia, 2014a) and experiencing NSSI (Mental Health First Aid Australia, 2014b). Use of these online guidelines have shown some promise for providing positive and empathic strategies to those who helped others with a mental health crisis (Hart, Jorm, Paxton, & Cvetkovski, 2012). However, there is a paucity of experimental or observational evidence on whether using these guidelines demonstrate better outcomes in SRB, NSSI or distress for those who have received help (Jorm & Ross, 2018).

While the included studies in our meta-analysis examined outcomes of asking after using self-reports, these results do not represent the challenges faced when people do not know how to ask verbally or how to help a person who is identified at risk. Schools also face a similar issue, by feeling ill prepared to respond to increased mental health

referrals and are unaware of available mental health resources (De Riggi, Moumne, Heath, & Lewis, 2017; Horowitz, Ballard, & Pao, 2009). To assist with facilitating the next step in care after screening for suicide risk, future research should examine how utilizing standardized care pathways help identify and connect those at risk to appropriate mental health resources (Brahmbhatt et al., 2019; Cappelli & Leon, 2017; Jabbour et al., 2018; U.S. Department of Health & Human Services, Health Resources & Services Administration, Maternal & Child Health Bureau, 2019). Furthermore, schools must have a tailored protocol and guidelines in place, as this will assist with developing timeframes to report NSSI behaviors, ensure all staff are trained to respond to NSSI, and help with re-directing those identified at-risk to appropriate mental health services (De Riggi et al., 2017; Hasking et al., 2016).

Given the above, ongoing evidence-based training should be provided to service providers to improve their comfort with assessing and treating suicidal patients which should translate to an increase in asking about SRB and NSSI. In addition, school staff should receive training on appropriate responses after a student reports NSSI, which includes actively listening and responding empathically, calmly, and compassionately (De Riggi et al., 2017; Hasking et al., 2016).

Strengths and Limitations

Our systematic review came with a number of strengths, including studies that inquire about NSSI and SRB, exploring how SRB and NSSI were asked about, and rating the quality and bias of the studies. Although this study provides empirical evidence to dismiss the fear of causing harm from asking about SRB or NSSI, we noticed that there were many different self-report measures and interviews used to ask about SRB or NSSI. Most of the studies often followed a similar process in order to safely inquire about SRB or NSSI by: (1) starting off with topics on emotions/health and gradually building toward asking about suicide and self-harm, (2) asking directly through either interview or self-report methods, and (3) having a plan in place/do something if a positive screen is indicated, whether it is re-directing to a professional, crisis service, hospital and providing local resources. While the majority of the studies included in this review relied on asking by using self-report questionnaires, under 50% of the included studies utilized a conversational method.

In terms of how to ask when conducting a face to face interview, two recommended ways are suggested: (1) Starting off with an incremental approach by first inquiring about general stress and emotions to provide a basis for asking about suicide (De Riggi et al., 2017; O'Reilly et al., 2016), or (2) by introducing a normalizing approach, whereby stipulating that asking is a requirement for all people (Horowitz et al., 2013; O'Reilly et al., 2016). It is also recommended to ask about the behavior directly as this information is less likely to be divulged without being asked (Horowitz et al., 2009; Johnson et al., 2019), and sensitively, as stigma-related concerns of embarrassment and feeling judged is often a barrier to disclosing (Hom et al., 2017).

While we reviewed all published empirical evidence to date on outcomes of asking about SRB and NSSI, a major limitation of our meta-analysis was that it was representative of asking non-clinical samples. Important ethical considerations were brought up

by Mathias et al. (2012), whereby it is not safe nor ethical to randomly assign vulnerable clinical samples who are at an elevated risk of suicide or harm to a "not asked" control group. There were also not enough studies in the current review to combine average effects for specific vulnerable samples (i.e., borderline personality disorder, substance use, current engagement in NSSI, suicide risk) or for serious adverse outcomes (e.g., suicide attempts, mortality, etc.), which limits our conclusions for these vulnerable groups. In addition, the majority of studies in this systematic review were unclear in their risk of bias and the cohort studies were of low quality. This was partially due to lack of clear reporting, inadequate control groups who were not asked, and extended time between follow-up points, where extraneous stressful situations could have contributed to changes in adverse outcomes.

Our risk of bias and quality assessment tools were originally created for rating medical studies, which may have contributed to lower quality ratings. For example, a component of the Newcastle-Ottawa scale was to establish that the outcome (e.g., disease) was not present at the beginning of the study. Most of the included studies could not establish that asking about SRB or NSSI resulted in negative effects for those who never thought about it in the first place, since asking about suicide or NSSI at the baseline assessment would be considered the "asking intervention" (e.g., Bjärehed et al., 2013). In fact, some included studies had utilized participants with a history of or current suicidal ideation/behaviors/NSSI, however it is unclear whether these behaviors were discovered and inquired about in the past (e.g., Reynolds et al., 2006). As some studies pointed out (Crawford et al., 2011; Muehlenkamp et al., 2015), baseline data on harmful outcomes of SRB and NSSI could not be collected in some control groups. The only baseline change in outcome this may have worked for was PD, and variations in PD at baseline were evident in a number of studies (Biddle et al., 2013; de Beurs et al., 2016; Gould et al., 2005; Harris & Goh, 2017).

Based on the available high quality RCT studies in community and school samples, it is OK to ask about SRB and NSSI. More high quality studies are needed that use verbal methods of asking, especially for vulnerable clinical samples. This is critical for public health surveillance purposes as well as for clinical purposes, so that appropriate prevention and treatment initiatives can be developed and implemented by health professionals.

DISCLOSURE STATEMENT

No conflicts of interest are reported beyond two of the authors being employed by the funder, the Public Health Agency of Canada (PHAC).

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AUTHOR NOTES

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